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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07957

332

Reg. Dist. No.

07959

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 213 Davis St				STREET ADDRESS (If rural give location) 213 Davis St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY (Middle) ELIZABETH (Last) ADKINS				(Month) JULY (Day) 5th (Year) 19 1957			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 6, 1883	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Quantico Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Franklin Rider				14. MOTHER'S MAIDEN NAME Kathryn Fessler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Edgar S. Adkins (Husband) 213 Davis St Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 38			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1948 , to 7/5 , 19 57 , that I last saw the deceased alive on 7/2 , 19 57 , and that death occurred at 7:45 P. M., from the causes and on the date stated above.							
SIGNATURE Dr. Fred Grasse				DATE SIGNED July 8 / 57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 8, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE JUL 10 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

1957

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Usual Residence		Place of Death	
Cause of Death		Manner of Death	
Physician's Signature		Medical Examiner's Signature	
Date of Death		Time of Death	
Place of Death		City and State	
County		Zip Code	
Registrar's Signature		Registrar's Office	
Date of Registration		Time of Registration	
Place of Registration		City and State	
County		Zip Code	

BUREAU V. 3

JUL 10 1957

RECEIVED

INSTRUCTIONS

FOR FILING IN MARIPOSA COUNTY

08016

CERTIFICATE OF DEATH

07958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 10 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestnut				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Delmar			
f. STREET ADDRESS 1 Chestnut				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Virgil Middle M. Last Adkins				4. DATE OF DEATH Month July Day 12 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 12 Days 12 Hours 1957	IF UNDER 24 HRS. Months 12 Days 12 Hours 1957	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asbury Adkins				14. MOTHER'S MAIDEN NAME Mary Parsons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Rosa Adkins, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Cardiac Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) 4 yr						INTERVAL BETWEEN ONSET AND DEATH 4 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957 , to July 12, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. H. Lyndol		M.D. Delmar Del		ADDRESS (Street, city or town, state) Delmar Del		DATE SIGNED July 14 '57	
PHYSICIAN'S NAME (Type) S. H. Lyndol		M.D. Delmar		ADDRESS (Street, city or town, state) Delmar		DATE SIGNED Del	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORY Farlows		22d. LOCATION (City, town, or county) (State) Pittsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marmel Co - Delmar, Del				24a. REC'D BY REGISTRAR DATE JUL 16 '57		24b. REGISTRAR'S SIGNATURE W. S. Marmel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. 21

JUL 16 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07959

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Wicomico</i> CITY (If outside corporate limits, write RURAL OR TOWN) <i>Salisbury</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>none</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>md</i> COUNTY <i>Wicomico</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> STREET ADDRESS (If rural, give location) <i>Evans St</i>	
3. NAME OF DECEASED (Type or Print) <i>Leidian</i> (First) <i>Beckett</i> (Middle) <i>md</i> (Last)		4. DATE OF DEATH (Month) <i>7</i> (Day) <i>5</i> (Year) <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>Sept 10, 1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE last birthday <i>72</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Leidian Robinson</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Robinson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no, or unk.) (If Yes, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT & ADDRESS <i>Wm Beckett</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>600.0 IMMEDIATE CAUSE (A) <i>Thromia</i></i> <i>ANTECEDENT CAUSE(S) DUE TO <i>Pyelonephritis chronic</i></i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7-1</i> , 19 <i>57</i> , to <i>7-5</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7-1</i> , 19 <i>57</i> , and that death occurred at <i>4:14</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>Wm B Smith</i>		ADDRESS (Street, city, town, state) <i>Wm B Smith md</i>	
DATE SIGNED <i>7-5-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>7-7-57</i>	NAME OF CEMETERY OR CREMATORY <i>Polks Rd. Cem</i>	LOCATION (City, town, or county) (State) <i>md</i>
24. REC'D BY REGISTRAR <i>Mary Kellam</i>	REGISTRAR'S SIGNATURE <i>Mary Kellam</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Booker McLeod</i>	ADDRESS <i>md</i>
DATE <i>7/12/57</i>			

CERTIFICATE OF DEATH

2107-20-12-1-1

BUREAU V. 2

JUL 12 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 8 Film 6218 7-29-57 et
CERTIFICATE OF DEATH

07961 337
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1 Lake Street Ext.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Bradford</u> Last <u>1892</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasoid</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/8/1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>?</u>			
14. MOTHER'S MAIDEN NAME <u>?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>			
16. SOCIAL SECURITY NO. <u>?</u>				17. INFORMANT <u>Gen Sen Hosp</u> Address <u>?</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Thrombosis</u> <u>026X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syphilis of CNS</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5, 1957</u> to <u>July 14, 1957</u> that I last saw the deceased alive on <u>July 13, 1957</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>He Carre I Hearn</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr CARRIE I HEARN</u>				DATE SIGNED <u>July 14, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Walking Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker H. Hearn</u>				24a. REC'D BY REGISTRAR <u>?</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloman</u>	

CERTIFICATE OF DEATH

ALABAMA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

PLACE OF DEATH

DECEASED

SEX

AGE

CAUSE OF DEATH

PLACE OF BIRTH

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. 5

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07962

CERTIFICATE OF DEATH

Reg. Dist. No.

07962

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) PENINSULA GENERAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City 23422			
f. NAME OF DECEASED (Type or print) Attie BYRD CHESSEB Bunting				g. DATE OF DEATH July 3rd 1957			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 2, 1877	
9. AGE (In years, last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME OLIVER CHESSEB				14. MOTHER'S MAIDEN NAME MOLLIE BYRD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GEORGE D. BUNTING, Pocomoke City, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. SKILX (b) Arteriosclerotic Cardiovascular DUE TO (c) Disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis and Cholelithiasis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1957 , to July 3, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 4:40 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas C. Hill, Jr.		M.D.		ADDRESS (Street, city or town, state) 224 N. Division St.		DATE SIGNED	
PHYSICIAN'S NAME (Type) THOMAS C. HILL, JR.		Salisbury, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-6-57		22c. NAME OF CEMETERY OR CREMATORY NELSON CEMETERY		22d. LOCATION (City, town, or county) (State) RURAL POCOMOKE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson		ADDRESS Pocomoke, MD.		24a. REC'D BY REGISTRAR JUL 8 1957		24b. REGISTRAR'S SIGNATURE Harry A. Thelmer	

BUREAU V. S.

JUL 8 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07963 **CERTIFICATE OF DEATH**

07963-237

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 322 Naylor St				STREET ADDRESS (If rural give location) 324 Naylor St.			
3. NAME OF DECEASED (Type or Print) LAURA ELLEN CALLAWAY				4. DATE OF DEATH (Month) July (Day) 1 st (Year) 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 23, 1864	9. AGE last birthday 93 yrs.	IF UNDER 1 YEAR Months 5 Days 8	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Sussex Co. MARYLAND Delaware		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Jonathan Beach				14. MOTHER'S MAIDEN NAME Mary Ellen Gordy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. J. Howard Dryden (Daughter) 322 Naylor St. Salisbury, Maryland		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. July 1, 1957				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 30, 1957 to July 1, 1957, that I last saw the deceased alive on June 30, 1957, and that death occurred at 2:00 A.M. from the causes and on the date stated above.							
SIGNATURE Dr. William Gray				DATE SIGNED July 1, 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF July 3, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE Mary J. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND	
DATE JUL 5 1957				ADDRESS (Street, city, town, state) M D. Camden Ave. Salisbury, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

JUL 5 1957

RECEIVED

CERTIFICATE OF DEATH

07964

Reg. Dist. No.

337

1 PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 410 Patterson Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM		Middle HENRY		Last CALLOWAY		4. DATE OF DEATH Month July	
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Jan. 1, 1872	
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months 6		IF UNDER 24 HRS Days 30		Hours 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cement Laborer Construction		10b. KIND OF BUSINESS OR INDUSTRY Georgetown, Delaware		11 BIRTHPLACE (State or foreign country) U S A		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME John Calloway		14 MOTHER'S MAIDEN NAME Sarah Rogers					
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bertha Calloway (Wife) Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart failure DUE TO degenerative heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 4-2-4-1		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 56 to July 31, 1957 , that I last saw the deceased alive on July 30, 1957 and that death occurred at 1:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Aug. 2 1957							
ACTUAL SIGNATURE Earl M. Beardsley		M.D.					
PHYSICIAN'S NAME (Type) EARL M. Beardsley		md. Ave - Salisbury, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Delaware	
23 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR AUG 5 1957	
				24b. REGISTRAR'S SIGNATURE Mary J. Holloway			

10 HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 5 1957

BUREAU V. S.

08017

CERTIFICATE OF DEATH

07965

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (Fruitland) St Luke Rd				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
f. STREET ADDRESS R.D.# 1 (Fruitland) St Luke Rd				g. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) IRVINE		First IRVINE		Middle FURNELL		Last CAUSEY	
4. DATE OF DEATH JULY		Month JULY		Day 21		Year 19 57	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 10 Days 24 Hours Min 		IF UNDER 24 HRS Months Days Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME James Causey				14. MOTHER'S MAIDEN NAME Annie Hitch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Mrs. Agnes Causey (Wife)				Address R.D.# 1 (St. Luke Rd Fruitland) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 to 7-21-57 , 19 57 that I last saw the deceased alive on 7-21-57 , 19 57 and that death occurred at 7:30P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Maryland DATE SIGNED July 22 1957							
PHYSICIAN'S SIGNATURE Dr. Lee Lawry				M.D. Winston M. L.			
PHYSICIAN'S NAME (Type) Dr. Lee Lawry				Fruitland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Sullen Cemetery (St. Luke-Wico Co. Near Fruitland, Md.)		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 25 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 25 1957

BUREAU V. 21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film

07966

CERTIFICATE OF DEATH

Reg. Dist. No.

08018

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Rivett 2</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daisey Lee Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Tause</u> Middle <u>Jr.</u> Last <u>Cherish</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23 1879</u>	
9. AGE (In years, last birthday) <u>78 1/2</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>19</u> Hours <u>19</u> Min <u>19</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana, Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Merritt</u>				14. MOTHER'S MAIDEN NAME <u>Fusella Cherish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Ralph Harris</u> Address <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>7/5</u> , 19 <u>57</u> , to <u>7/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/12/57</u> , and that death occurred at <u>8:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. R. Grance</u>				ADDRESS (Street, city or town, state) <u>Snow Hill, Md</u>			
PHYSICIAN'S NAME (Type) <u>F. R. Grance</u>				DATE SIGNED <u>7/12/57</u>			
22a. RURAL CREMATION, REMOVAL (Specify) <u>None</u>				22b. DATE THEREOF <u>July 14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	
22d. LOCATION (City, town, or county) <u>Stacston</u>				22e. (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton B. Brown</u>				ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 15 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Ray H. Hallway</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08019

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2 (Shad Point) Box# 225				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LANDONIA Middle GRAY Last COLONIA		4. DATE OF DEATH Month July Day 15 Year 19 57		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1884		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 20 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia (Greenbackville)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gordon Pilchard				14. MOTHER'S MAIDEN NAME Louisiana Redden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Henry E. Colona (Husband) R.D.# 2 (Shad Point) Box# 225 Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension C.V. Disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 6 months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 434.1							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-2 , 19 55 , to 7-15 , 19 57 , that I last saw the deceased alive on 7-14 , 19 57 , and that death occurred at 11:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Earl L. Royer M.D.				PHYSICIAN'S NAME (Type) Dr. Earl L. Royer Camden Ave. Salisbury, Maryland July 16 / 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 18 1957			
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

JUL 18 1957

RECEIVED

07965

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomack</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHINCOTEAGUE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>			d. STREET ADDRESS <u>111 COLONA ST.</u>		
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>COLONA</u> Last <u>COLONA</u>			4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John T. Daisy</u>			14. MOTHER'S MAIDEN NAME <u>Mariah Thornton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT <u>Mrs. Anne Mason, Pocomoke, Md</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>11/20/1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Entry Heart Disease</u> DUE TO (c) <u>Myocardial Insufficiency</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>57</u> to <u>7/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/28</u> , 19 <u>57</u> , and that death occurred at <u>10:25</u> A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>David J. Gilman</u> M.D.			ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury Md July 30, 1957</u>		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beriah</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter M. Clark</u>			ADDRESS <u>Chincoteague Va</u>		24a. REC'D BY REGISTRAR DATE <u>7 30 57</u>
			24b. REGISTRAR'S SIGNATURE <u>Margill H. Holtz</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07969

07966

CERTIFICATE OF DEATH

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury - RFD #4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Snow Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Corbin</u> Last <u>Corbin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1884</u>	9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>med</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-32-1101</u>		17. INFORMANT <u>Edward Corbin</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>610x Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Endic. hypertens. of the prostate</u> DUE TO (c) <u>Bilateral pyelonephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-6-57</u> , 19 <u>57</u> , to <u>7-25-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-25-57</u> , 19 <u>57</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carl L. Rayer</u> M.D.				ADDRESS (Street, city or town, state) <u>407 Garden Ave.</u>		DATE SIGNED <u>7-26-57</u>	
PHYSICIAN'S NAME (Type) <u>Carl L. Rayer, M.D.</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Mortuary</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin West</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Aug 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>May H. Holloway</u>	

RECEIVED

NOV 1 1907

BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 P. 1-10 7-20-57 et

08020

CERTIFICATE OF DEATH

07970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards	c. LENGTH OF STAY IN 1b 50yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX		e. STREET ADDRESS XXXXXX	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNE Middle S. Last DAVIS		4. DATE OF DEATH Month July Day 22 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25 1867
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Esham		14. MOTHER'S MAIDEN NAME Sarah Magee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XXX	
17. INFORMANT Mr. Walter Davis		Address Willards, Md.	
18. CAUSE OF DEATH [Enter only one cause per line; for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chr. Nephritis cause (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4, 1957 , to July 22, 1957 , that I last saw the deceased alive on July 21, 1957 , and that death occurred at 6 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas. R. Law		ADDRESS (Street, city or town, state) Berlin Md	
PHYSICIAN'S NAME (Type) M.D.		DATE SIGNED 7-23-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 7/24/57		22b. DATE THEREOF 7/24/57	
22c. NAME OF CEMETERY OR CREMATORY New Hope		22d. LOCATION (City, town, or county) (State) Willards Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Schuppert		24a. REC'D BY REGISTRAR DATE 25 1957	
ADDRESS Schuppert		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

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JUL 25 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07967

CERTIFICATE OF DEATH

Reg. Dist. No.

07971

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3½</u> hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Near Williamsburg</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin</u> <u>Davis</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>10</u> <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Davis</u>				14. MOTHER'S MAIDEN NAME <u>Kruscha Meekins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Hospital records</u> Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis, general</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia due to Cerebral thrombosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>57</u> , to <u>July 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>57</u> , and that death occurred at <u>2 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. J. Guerman</u>		M.D. <u>Deer's Head State Hospital</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>7/10/57</u>	
PHYSICIAN'S NAME (Type) <u>V. J. Guerman, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Hurlock, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Exumpton Son Federalburg md</u>				24a. REC'D BY REGISTRAR DATE <u>7-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

RECEIVED

JUL 15 1957

BUREAU Y. B.

08021

CERTIFICATE OF DEATH

07972
Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# Pittsville,		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle VALENTINE Last DENNIS		4. DATE OF DEATH Month JULY Day 13 th 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single	8. DATE OF BIRTH October 22, 1883
9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 8 Day 21	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Marcellus Dennis		14. MOTHER'S MAIDEN NAME Laura Ann Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. Robert A. Dennis (Brother)		Address R.D.# Pittsville - Powellville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) 		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 3-5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 to day of death that I last saw the deceased alive on 7-12 19 57 , and that death occurred at 2:15 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL Frank Lewis M.D. 7-16-57			
PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		Willards, Maryland July 14 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 15, 1957	22c. NAME OF CEMETERY OR CREMATORY Dennis Family Cemetery R.D.# Pittsville-Powellville, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8022

CERTIFICATE OF DEATH

Reg. Dist. No.

07973

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Siloam c. LENGTH OF STAY IN 1b 19 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eden Rt. #2				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Siloam d. STREET ADDRESS Eden Rt. #2 • IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) LAWRENCE First DAVIS Middle DENSON Last		4. DATE OF DEATH Month 7 Day 7 Year 1957		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4, 1904		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 1957					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farming				10b. KIND OF BUSINESS OR INDUSTRY Own Farm				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ephrem A. Denson				14. MOTHER'S MAIDEN NAME Emma Lawrence				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 220-34-9972				17. INFORMANT Mrs. Lua Denson, Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 hrs.												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/10, 1956 to 7/7, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 21 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 7/8/1957 ACTUAL SIGNATURE E. M. Beardsley PHYSICIAN'S NAME (Type) E. M. Beardsley, 207 Maryland Ave., Salisbury, Maryland																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/10/57				22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery				22d. LOCATION (City, town, or county) Siloam, Maryland (State)							
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland ADDRESS Norman F. Baker				24a. REC'D BY REGISTRAR DATE 7-18-57				24b. REGISTRAR'S SIGNATURE Mary W. Beidman											

RECEIVED
JUL 11 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07968

CERTIFICATE OF DEATH

07974

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Fleetwood</u> Last <u>Disharoon</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--Used Furniture Dealemk.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>West Post Office, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marcellus Disharoon</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Pusey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) <u>nk.</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>213-24-4983A</u>		17. INFORMANT <u>Mr. Howard W. Disharoon (Son)</u> <u>Deer's Head Hospital records, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>57</u> , to <u>July 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>		M.D. <u>Deer's Head State Hospital</u>		DATE SIGNED <u>7/6/57</u>			
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>		<u>Salisbury, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME -- SALISBURY, MD.</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>		

BUREAU V. E.

107 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07975 332
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1 (Near Fruitland)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ROY Last ENNIS				4. DATE OF DEATH Month JULY Day 29th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1898		9. AGE (in years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 5 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming on Farm		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Edward Ennis				14. MOTHER'S MAIDEN NAME Clarissa Jane Smullen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ella L. Ennis (Wife) R.D.# 1 (Near Fruitland) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Salisbury
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 30 1957	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORY Smullen Cemetery		22d. LOCATION (City, town, or county) (State) (St. Luke-Worcester Co. Maryland)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Mary F. Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1843. Page 5 may be retained for your files. Prior to burial, cremation, or removal, DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

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JUG 1 1957
BUREAU V. S.

may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07969

CERTIFICATE OF DEATH

07976 33x
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cloverdale Rd				d. STREET ADDRESS Cloverdale Rd.			
3. NAME OF DECEASED (Type or print) First ROSA Middle ETTA Last FARLOW				4. DATE OF DEATH Month July Day 14 Year 57			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 1, 1873	9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 13 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) R.D.# Salisbury, Maryland		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME John Wesley Parker				14. MOTHER'S MAIDEN NAME Laura Ann Maddox			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO		17 INFORMANT Mrs. Clyde B. Hastings (Daughter) Address Cloverdale Road Salisbury, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Decompensation 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 46 , 19 46 , to 7-14-57 , 19 57 , that I last saw the deceased alive on 7-14-57 , 19 57 , and that death occurred at 5:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Md DATE SIGNED July 17, 1957							
ACTUAL SIGNATURE Lee Lawry M.D.		PHYSICIAN'S NAME (Type) Dr. Lee Lawry		Fruitland, Maryland		July 17, 1957	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 18 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. S.

JUL 18 1957

RECEIVED

07970

07977

CERTIFICATE OF DEATH

Husband—Wm J. Gordy Jr. (Deceased)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 Park Ave.				d. STREET ADDRESS 403 Park Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle CLARA Last GORDY				4. DATE OF DEATH Month JULY Day 15 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John H. White				14. MOTHER'S MAIDEN NAME Annette Vickers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 		17. INFORMANT Mrs. J. Cleveland White (Nephew) Address 1546 Fleneagle Rd. Zone #12 Baltimore, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190x Metastatic malignant melanoma to the DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day 19 Hour a. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 27, 1957 to July 15, 1957 that I last saw the deceased alive on 7/15/57 19 and that death occurred at 6 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St. Salisbury, Maryland DATE SIGNED July 16, 1957							
ACTUAL SIGNATURE Dr. Fred Grange M.D. S. Division St. Salisbury, Maryland				PHYSICIAN'S NAME (Type) Dr. Fred Grange			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City town or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR July 18 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU V. P.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07978

Reg. Dist. No.

337

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission, a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Parson's</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Parson's General Hospital</u>		d. STREET ADDRESS <u>RFD #1</u>	
3 NAME OF DECEASED (Type or print) <u>Robert J. Hamblin</u>		4. DATE OF DEATH <u>7-19-57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR <u>7</u> Months <u>26</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Parson's</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert J. Hamblin</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Martha Parson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1377</u>	
17. INFORMANT <u>Mrs. Margaret Hamblin - wife - Parson's, Md.</u>		Address <u>Parson's, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus; thrombosis iliac vein</u> 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sub-dural hematoma</u> (c), stating the underlying cause lost. (c) <u>Days 2</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke and fall from wheelchair</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>7-17-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>7-20-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Grove Cemetery</u>	22d. LOCATION (City, town, or county) <u>Salisbury, Md.</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. ...</u>		24a. REC'D BY REGISTRAR <u>Walter J. ...</u> 24b. REGISTRAR'S SIGNATURE <u>Walter J. ...</u>	

JUL 30 1957

RECEIVED

JUL 30 1957

BUREAU V. E.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07979

Reg. Dist. No.

08024

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 89 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 500 Chestnut				d. STREET ADDRESS 500 Chestnut			
3. NAME OF DECEASED (Type or print) First Eva Middle Kathleen Last Hastings				4. DATE OF DEATH Month July Day 9 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1867	
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Wicomico County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Hezekiah Hastings				14. MOTHER'S MAIDEN NAME Mary Hastings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Martha Hastings, Delmar, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Asphyxia 72x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 2 1/2 in							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Delmar				20g. (County) Wicomico		20h. (State) Delaware	
21. I certify that I attended the deceased from April , 19 47 , to July 9 , 19 57 , that I last saw the deceased alive on July 9 , 19 57 , and that death occurred at 9:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lynch				M.D. Delmar, Del July 31-57			
PHYSICIAN'S NAME (Type) S. H. Lynch				DATE SIGNED July 31-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Hamel Co - Delmar, Del				24a. REC'D BY REGISTRAR DATE 1-1-57		24b. REGISTRAR'S SIGNATURE W. S. Hamel	

BUREAU V. T.

JUL 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07972 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07980 33v

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick General Hospital</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>607 E. Church St.</u>	
3 NAME OF DECEASED (Type or print) <u>Nathaniel Franklin Hobbs</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-25-1879</u> 9. AGE (In years last birthday) <u>78</u> yrs IF UNDER 1 YEAR <u>7</u> Months IF UNDER 24 HRS <u>23</u> Hours <u>57</u> Min		4. DATE OF DEATH <u>7</u> <u>23</u> <u>19 57</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Nathaniel Franklin Hobbs</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>17-07-0018</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Nickerson</u> 17. INFORMANT <u>Woodrow Hobbs, Clayton, Del.</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> 153X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the sigmoid</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Expired following surgery for resection of the sigmoid.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Earl L. Royer</u> EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>7-23-57</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-27-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial</u> 22d. LOCATION (City, town, or county) <u>Salisbury, Md.</u> (State) _____		24a. REC'D BY REGISTRAR <u>7/30/57</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Gamel</u> ADDRESS <u>Frederick, Md.</u>			

BUREAU V. B.

JUL 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07973

CERTIFICATE OF DEATH

07981334
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wocinico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Priscilla St				d. STREET ADDRESS 409 Priscilla St			
3. NAME OF DECEASED (Type or print) First HENRIETTA Middle HOLLOWAY Last HOLLOWAY				4. DATE OF DEATH Month July Day 19 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 26, 1868	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 23 Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Sussex County Delaware	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Noble C. Baker				14. MOTHER'S MAIDEN NAME Lavenia Wyatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Agnes Owens (Daughter)				Address 409 Priscilla St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4 22 57 (b) (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Degenerative heart disease - congestive heart failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 19 54 to 7/19 57 , that I last saw the deceased alive on 7/19 57 , and that death occurred at 6:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. Salisbury, Maryland DATE SIGNED July 20/57							
ACTUAL SIGNATURE Earl Beardsley M. D.							
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley				Maryland Ave. Salisbury, Maryland July 20/57			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF July 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery		22d. LOCATION (City, town, or county) (State) R. D. # Parsonsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 22 1957 24b. REGISTRAR'S SIGNATURE Harry H. Holloway			

BUREAU V. S.

1957

RECEIVED

07974

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE Maryland c. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp				d. STREET ADDRESS Route # 3			
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Hudson				4. DATE OF DEATH Month Day Year 7 13 57			
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1892	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chemical Plant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Purnell				14. MOTHER'S MAIDEN NAME Mary Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 195-05-5016		17. INFORMANT Address Mrs. Selena Hudson, Berlin, Md. Rt #3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 31, 1957 , to July 13, 1957 , that I last saw the deceased alive on July 13, 1957 , and that death occurred at 1:40 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Eugene J. Lumberge M.D.				PHYSICIAN'S NAME (Type) Salisbury Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-18-1957		22c. NAME OF CEMETERY OR CREMATORY Germanatown Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR 19 1957		24b. REGISTRAR'S SIGNATURE Mary H. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 13 1957

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RECEIVED

JUL 15 1957

BUREAU V. 3

07976

CERTIFICATE OF DEATH

07984
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma H. Jones		4. DATE OF DEATH 7 13 1957	
5. SEX F M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 14 1871
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elisha Williams		14. MOTHER'S MAIDEN NAME Louise Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louise Roberts		Address 300 Delaware St., Salisbury Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) degenerative heart disease DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 40 yrs.		INTERVAL BETWEEN ONSET AND DEATH 27 months Indefinite	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 May 1957 to 13 July 1957 that I last saw the deceased alive on 13 July 1957 and that death occurred at 9 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 16 July 1957	
ACTUAL SIGNATURE E. A. Purnell M.D.			
PHYSICIAN'S NAME (Type) Dr. E. A. Purnell		652 W. Main St., Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-16-1957	22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery	22d. LOCATION (City, town, or county) (State) Deal Island, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart		ADDRESS Funeral Home, Salisbury, Md.	
24a. REC'D BY REGISTRAR 19 JUL 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 19 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07977

CERTIFICATE OF DEATH

07985

Reg. Dist. No. 737

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ellen</u> <u>Kearney</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>12</u> <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/17/1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Slava Kearney</u>		14. MOTHER'S MAIDEN NAME <u>Maria Siree</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>42.2.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>52</u> , to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>57</u> , and that death occurred at <u>8:28 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Juerman</u> M.D.				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>7/13/57</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 17 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

BUREAU V. S.

17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07978

CERTIFICATE OF DEATH

07986

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tyaskin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BASIL Middle E. Last LARMORE				4. DATE OF DEATH Month July Day 18 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/20/1885		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months 8 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY American Can Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George C.H. Larmore				14. MOTHER'S MAIDEN NAME Nettie Dickerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Alice Larmore, Tyaskin, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 72X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 7-21 , 19 57 , and that death occurred at 2 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED 7-21-57							
ACTUAL SIGNATURE Wilbur R. Ellis, Jr. M.D.				PHYSICIAN'S NAME (Type) Wilbur R. Ellis, Jr. Medical Center, Salisbury, Md. 7/21/			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/57		22c. NAME OF CEMETERY OR CREMATORY Tyaskin Cem.		22d. LOCATION (City, town, or county) (State) Tyaskin, Maryland 57	
23. FUNERAL DIRECTOR'S SIGNATURE C. D. Mersbach Bivalve, Maryland				24a. REC'D BY REGISTRAR DATE JUL 26 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 26 1957
BUREAU V. B.

07987 337

(7979)

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wiconico MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
c. LENGTH OF STAY IN 1b 1 week				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Rufus N. Middle Layfield Last Layfield				4. DATE OF DEATH Month July Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1882	
9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months 7 Days 13 Hours 13 Min 13		IF UNDER 24 HRS. Months 7 Days 13 Hours 13 Min 13			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME James Layfield			
14. MOTHER'S MAIDEN NAME Virginia Layfield				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO no				17. INFORMANT Mrs. Rufus Layfield Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carbonism (Arteriosclerotic)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury (County) Princess Anne (State) Md.				20g. (City or town) Salisbury (County) Princess Anne (State) Md.			
21. I certify that I attended the deceased from June 18, 1957 to July 7, 1957 that I last saw the deceased alive on July 10, 1957 and that death occurred at 2:30 p.m. from the cause and on the date stated above.				ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED July 13, 1957			
ACTUAL SIGNATURE David J. Gilmore M.D.				PHYSICIAN'S NAME (Type) David J. Gilmore			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-57		22c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian		22d. LOCATION (City, town, or county) Princess Anne, Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Turn R. Watson ADDRESS Princess Anne, Md.				24a. REC'D BY REGISTRAR 18 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU W. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07988

07980

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>R. F. D. # 3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>Lindsey</u> Last <u>Lindsey</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20, 1893</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>64</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				11. BIRTHPLACE (State or foreign country) <u>Chestertown</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Broadway</u>				14. MOTHER'S MAIDEN NAME <u>Laura Graves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>N</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral hemorrhage with left hemiplegia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease, decompensated</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u> </u> Day <u>19</u> Year <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>6/28/1954</u> to <u>7/16/1957</u> , that I last saw the deceased alive on <u>7/15/1957</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. V. Guerman</u> M.D.				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>			
DATE SIGNED <u>7/16/57</u>							
PHYSICIAN'S NAME (Type) <u>V. Guerman, M.D.</u>				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>7-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Wallay</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>Mary A. Holloway</u>				DATE <u>18 1957</u>			

RECEIVED

JUL 18 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7981

CERTIFICATE OF DEATH

07989

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eulalia Lloyd		4. DATE OF DEATH Month July Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1879
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David K. Davis		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old CVA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 8 , 19 57 , to July 10 , 19 57 , that I last saw the deceased alive on July 10 , 19 57 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) Deer's Head State Hospital	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		DATE SIGNED 7/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 13 1957	Monrovia Cemetery	Braddock Pa
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS Waldorf	24a. REC'D BY REGISTRAR 15 1957
		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar. Prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 15 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be completed within 24 hours after death. The attending physician or hospital may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07982

07990

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		COUNTY Wicomico		STATE Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 123 West Locust St				STREET ADDRESS (If rural give location) 123 West Locust St			
3. NAME OF (First) (Middle) (Last) PURNELL CORNELIUS MADDOX (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year) July 4 th 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 20, 1871		9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auctioneer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wicomico County Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph M. Maddox				14. MOTHER'S MAIDEN NAME Sarah Martha Shockley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS Mrs. Cassie M. Maddox (Wife) 123 West Locust St. Salisbury, Maryland			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 44001 Cardiac arrest				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Semility							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Coronary Thrombosis							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/4, 1954, to July 4, 1957, that I last saw the deceased alive on 7/1, 1957, and that death occurred at 3:45 AM, from the causes and on the date stated above.							
SIGNATURE Dr. Andrew C. Mitchell		M. D. Maryland Ave. Office-Salisbury, Md.		DATE SIGNED July 5 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 6, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

BUREAU V. 8

8 1957

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

It is to be filled out by the funeral director. 7983 30/57L CERTIFICATE OF DEATH

07991 337 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Trumbull</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Warren</u> 72x-1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>				d. STREET ADDRESS <u>438 Waverly Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>(Geng)</u> Last <u>MARIS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10 - 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Chios Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>				13. FATHER'S NAME <u>Kon Falas</u>			
14. MOTHER'S MAIDEN NAME <u>d/o Record</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mr. Theodore A. Maris (Son)</u> Address <u>438 Waverly Ave. Warren, Ohio</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10, 1957</u> to <u>July 10, 1957</u> , that I last saw the deceased alive on <u>July 10, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr.</u> M.D. <u>Medical Center Salisbury, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr.</u> <u>July 11, 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Weirton, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>Jul 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary St. Holloway</u>	

BUREAU V. S.

JUL 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7984

CERTIFICATE OF DEATH

07992 237
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>NEW Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ONANCOCK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Hill Private Sanitarium</u>		d. STREET ADDRESS <u>Kerr</u>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>MILLS</u> Last <u>MILLS</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>8TH</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Nov. 30, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Toronto, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Francis Sibbold</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Mrs. C. W. Newman</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral stroke</u> <u>44 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>44 X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/7</u> , 19 <u>57</u> to <u>7-8</u> , 19 <u>57</u> that I last saw the deceased alive on <u>7/8</u> , 19 <u>57</u> , and that death occurred at <u>1:23 P</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. William Smith</u> M.D. <u>Medical Center Salisbury, Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Wm. Smith</u>		<u>Med. Center</u> July 8 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ONANCOCK</u>	22d. LOCATION (City, town, or county) (State) <u>ONANCOCK Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carlisle M. Williams</u>		24a. REC'D BY REGISTRAR DATE <u>11 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary N. Williams</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 11 1957

BUREAU V. M.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17985

CERTIFICATE OF DEATH

07993

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>LOCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENNSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>SOUTH MAIN STREET</u>			
3. NAME OF DECEASED (Type or print) <u>ALFRED RUSSELL MITCHELL</u>				4. DATE OF DEATH <u>JULY 21 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 18, 1902</u>	9. AGE (In years, last birthday) <u>54 yrs.</u>	10. UNDER 1 YEAR IF UNDER 24 HRS		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY C MITCHELL</u>				14. MOTHER'S MAIDEN NAME <u>BELLE SHARP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO <u>215-28-3864</u>			
17. INFORMANT <u>Mrs. A. R. MITCHELL</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Angioplastic Carcinoma (metastatic) of Brain</u> <u>162x</u> DUE TO (b) <u>Bronchiogenic Carcinoma, Left (?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>> 12 mos (?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>57</u> , to <u>7/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>57</u> , and that death occurred at <u>1045</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr</u>				ADDRESS (Street, city or town, state) <u>3215 DIV ST</u>			
PHYSICIAN'S NAME (Type) <u>Rufus S. GARDNER Jr</u>				DATE SIGNED <u>7/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>JUL 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>			

RECEIVED

JUL 24 1957

BUREAU V. S.

07986

CERTIFICATE OF DEATH

07994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 5 Mo.				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. STREET ADDRESS 423 Pinehurst Ave.,			
3. NAME OF DECEASED (Type or print) First Middle Last William S. Sydney Moore				4. DATE OF DEATH Month Day Year 7 21 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 22, 1871	
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Banker				10b. KIND OF BUSINESS OR INDUSTRY Pres. Bank		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William S. Moore				14. MOTHER'S MAIDEN NAME Laura Griffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO None		17. INFORMANT Address William S. Moore Jr. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral - vascular accident DUE TO (b) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on July 20, 1957 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 7-21-57							
ACTUAL SIGNATURE A. C. Mitchell				PHYSICIAN'S NAME (Type) A. C. Mitchell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/57		22c. NAME OF CEMETERY OR CREMATORY ST. John's Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE 7-25-57		24b. REGISTRAR'S SIGNATURE Norman F. Baker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 25 1957

BUREAU V. 3

07987

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>W. CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1144</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2. FALLS CHURCH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>T. J. MORGAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRENN A LEE MORGAN</u>				4. DATE OF DEATH Month Day Year <u>JULY 21 19 57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 17, 1956</u>	9. AGE (In years last birthday) yrs <u>1</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>BENNY MORGAN</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL TOOKEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>MR. BENNY MORGAN</u>				Address <u>PARSONSBURG MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>344X</u> (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrocephalus with bilateral anastomosis. Meningitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>57</u> , to <u>July 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>57</u> , and that death occurred at <u>5:00 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Sanders</u> M.D.				ADDRESS (Street, city or town, state) <u>926 Division St Salisbury, Md</u>			
DATE SIGNED <u>7/21/57</u>							
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/23/57</u>		<u>TAYLORVILLE</u>		<u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burby</u>				ADDRESS <u>Berlin Md</u>		24a. RECEIVED BY REGISTRAR <u>DATE 23 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 28 1957

BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07988

CERTIFICATE OF DEATH

07996

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>HATCHER, ST.</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First Middle Last <u>MORRIS</u>				4. DATE OF DEATH <u>July</u> Month <u>21st</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/1/88</u>	
9. AGE (In years lost birth day) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>EARNCK G. MORRIS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE TURNER.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>221-12-0005</u>		17. INFORMANT <u>MINCKVA MORRIS FRANKFORD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-18</u> , 19 <u>57</u> , to <u>7-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-21</u> , 19 <u>57</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>William B. Ellis Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REBURYAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u>				ADDRESS <u>Frankford, Del.</u>		24a. REC'D BY REGISTRAR <u>25 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

RECEIVED

JUL 25 1957

BUREAU V. 2

07989

CERTIFICATE OF DEATH

Reg. Dist. No.

322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>EDEN</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MORTON</u>				4. DATE OF DEATH Month Day Year <u>July 27 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1957</u>	9. AGE (In years last birthday) yrs. <u>1</u>	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min <u>1 45</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES WILLIAM MORTON</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>176x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.) <u>400 E. Church St.</u>	
				20f. (City or town) <u>Salisbury Md</u>		(County) (State)	
21. I certify that I attended the deceased from <u>July 27, 1957</u> , to <u>July 27, 1957</u> , that I last saw the deceased alive on <u>July 27, 1957</u> , and that death occurred at <u>12:57 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.				ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury Md</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>				DATE SIGNED <u>7/28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-30-57. Peninsula General Hospital</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury Md</u>		22d. LOCATION (City, town, or county) (State) <u>Wicomico Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>				24a. REC'D BY REGISTRAR DATE <u>7-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Henry M. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20-2366XV0

BUREAU V. S.

AUG 1 1905

RECEIVED

BUREAU V. S.

1907

RECEIVED

1.
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07999
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Pocomoke</u>	
3. NAME OF DECEASED (Type or print) <u>William A. Northcutt</u>		4. DATE OF DEATH <u>7-24-57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1925</u>
9. AGE (In years last birthday) <u>32 yrs</u>		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>4</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Northcutt</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>256-28-8201</u>	
17. INFORMANT <u>Mrs Pauline Northcutt, Pocomoke, Md.</u>		Address <u>Pocomoke, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9028</u> <u>2nd degree fracture C-5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severed cervical cord</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Drove into C-5 of water and struck head on ground.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>7-21-57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marilla Beach</u>	20f. (City or town) <u>Pocomoke</u> (County) <u>Wicomico</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>7-24-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 30, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bascom Cemetery</u>	22d. LOCATION (City, town, or county) <u>Hilltonia, Georgia</u>
23. FINEST DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		24a. REC'D BY REGISTRAR <u>JU</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
ADDRESS <u>Pocomoke, Md.</u>		DATE <u>7-24-57</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07992 **CERTIFICATE OF DEATH**

Reg. Dist. No.

08000

337

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First William Middle Luther Last Nutter				4. DATE OF DEATH Month 7 Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE AA		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH August 7, 1907	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel E. Nutter				14. MOTHER'S MAIDEN NAME Annie Horner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-16-6927		17. INFORMANT Address Mrs. Evelyn Nutter, Nanticoke, Md.			
18 CAUSE OF DEATH [Enter only one cause, periling for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Cirrhosis of the Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrointestinal Hemorrhage							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 9 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Wicomico		20h. (State) Md.	
21. I certify that I attended the deceased from July 12, 1957 to July 23, 1957 that I last saw the deceased alive on July 23, 1957 and that death occurred at M from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED July 24, 1957							
ACTUAL SIGNATURE David E. Gilmore M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-57		22c. NAME OF CEMETERY OR CREMATORY Nanticoke Cemetery		22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md				24a REC'D BY REGISTRAR JUL 31 1957		24b. REGISTRAR'S SIGNATURE Mary A. Holloway	

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUL 31 1957

BUREAU V. S.

BUREAU V. S.

JUL 31 1957

RECEIVED

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The following copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07993 CERTIFICATE OF DEATH

Reg. Dist. No.

08001

332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS 104 Wade St.			
3. NAME OF DECEASED (First) (Middle) (Last) SALLIE POPE				4. DATE OF DEATH (Month) (Day) (Year) JULY 7th 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH August 31, 1870	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Irving Hitch				14. MOTHER'S MAIDEN NAME Sarah Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Minnie Muir (Daughter) 104 Wade St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 7 days			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1957 to July 7, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. William Gray		M.D. Camden Ave. Salisbury, Maryland		DATE SIGNED July 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 10, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE William H. Gray		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			
DATE JULY 11 1957							

RECEIVED

JUL 11 1957

BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07994
CERTIFICATE OF DEATH

08002
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u> <u>Route #2.</u>			
d. STREET ADDRESS <u>A 200 7</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>R.</u> Last <u>POWELL</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957.</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 1 - 1894</u>	
9. AGE (In years, last birthday) <u>63 11/27</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Nathaniel Pusey</u>			
14. MOTHER'S MAIDEN NAME <u>Annie Cannon</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Ms Annie R. Street</u> Address <u>1304 216 Clementon N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO (b) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1304 216</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>2 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 22, 1957</u> to <u>July 22, 1957</u> that I last saw the deceased alive on <u>July 22, 1957</u> and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilman</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>July 22, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 26/57</u>		<u>Christian Cemetery</u>		<u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay C. Gimmis</u>				ADDRESS <u>Snow Hill, Md</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>			

RECEIVED

JUL 24 1957

BUREAU V. S.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7995

08003

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before death, as on, a. STATE <u>New York</u> b. COUNTY <u>Bronx</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u>	
c. LENGTH OF STAY IN 1b <u>1 hour</u>		d. STREET ADDRESS <u>210 W. 14th St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RE <input type="checkbox"/> A FMR <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Lewis</u> Last <u>Redd</u>		4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>A, A.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/1926</u>
9. AGE (In years last birthday) <u>30</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. IF UNDER 24 Hrs Hours <u>0</u> Min <u>0</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>William Redd</u>		14. MOTHER'S MAIDEN NAME <u>Jeanette Baughman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>110</u>	
17. INFORMANT <u>James L. Perkins, 210 W. 14th St. N.Y.C.</u>		Address <u>N.Y.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. IMMEDIATE CAUSE BY IMMEDIATE CAUSE (a) <u>Crushed skull</u>			
DUE TO <u>100%</u>			
Conditions, if any, which gave rise to immediate cause (b) <u>100%</u>			
(c) <u>100%</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>100%</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in car that collided with a trailer truck.</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-27-57</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RFD #13</u>	20f. (City or town) (County) (State) <u>Pocomoke Worcester Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>7-29-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Douglass Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. STEWART</u>		24a. REGISTRY REGISTRAR <u>SUL 31</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		DATE <u>7-31-57</u>	

RECEIVED

JUL 31 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07996

CERTIFICATE OF DEATH

08004

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived (If institution: Reg. Dist. No. Caroline) a. STATE Maryland b. COUNTY XXXXXX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				d. STREET ADDRESS 319 S. 2nd St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRANCIS Middle IRVING Last REYNOLDS				4. DATE OF DEATH Month JULY Day 16 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1868		9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min 88	IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Rubber Employee				10b. KIND OF BUSINESS OR INDUSTRY Middletown, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Reynolds				14. MOTHER'S MAIDEN NAME Mary Rothwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) Unk				16. SOCIAL SECURITY NO. Mr. William A. Reynolds (Son)		17. INFORMANT (Address) 45 Uclid Ave. Cleveland 3, Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour 19 a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-11-57 , 19 57 , to 7-16-57 , 19 57 , that I last saw the deceased alive on 7-16-57 , 19 57 , and that death occurred at 10:25P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 116 E. Main St. Salisbury, Md. DATE SIGNED 7-17-57							
ACTUAL SIGNATURE Philip A. Insley M.D. Salisbury, Md.				PHYSICIAN'S NAME (Type) Dr. Philip A. Insley			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 19, 1957			
22c. NAME OF CEMETERY OR CREMATORY Drawyer's Cemetery				22d. LOCATION (City, town, or county) (State) Near Odessa Delaware			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 19 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

U. S. DEPT. OF JUSTICE

RECEIVED

07997

CERTIFICATE OF DEATH

08005337
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		2. USUAL RESIDENCE (Where deceased lived If institut on residence before admision) a. STATE <u>New Jersey</u> b. COUNTY <u>Camden</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haddonfield</u> d. STREET ADDRESS <u>454 Elm ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Clayton</u> Middle <u>J.</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1957</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 - 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver J. Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Bowen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>246-07-6244</u>	
17. INFORMANT <u>Walden J. Richardson</u>		Address <u>Haddonfield NJ</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/19</u> , 19 <u>57</u> , to <u>7/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/19</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>		ADDRESS (Street, city or town, state) <u>512 E. Market St. Snow Hill, Md.</u> DATE SIGNED <u>7/19/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whalecoast Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Grooms</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Thos. H. Williams</u>	
DATE <u>JUL 22 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 22 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07998

CERTIFICATE OF DEATH

08096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>614 Westover Circle</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Annie Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO <u>21925-3645H</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>recurrent cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease, decompensated</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15</u> , 19 <u>57</u> , to <u>July 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>57</u> , and that death occurred at <u>9:45A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>7/17/57</u> ACTUAL SIGNATURE <u>V. Juerman</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-17-57</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Deer's Head State Hospital</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 22 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Harry J. Hallaway</u>			

BUREAU V. S.

1957

RECEIVED

331

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

BUREAU V. S.

AUG 5 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08000

CERTIFICATE OF DEATH

08008.337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marion Middle Edna Last Roswell				4. DATE OF DEATH Month July Day 15 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1891	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Robins				14. MOTHER'S MAIDEN NAME Unknown Frink			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Paul Roswell, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary Thrombosis DUE TO Arteriosclerosis of Coronary Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO Myocardial Infarction (c) Myocardial Infarction							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11-20-1							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 30, 1957 , to July 14, 1957 , that I last saw the deceased alive on July 14 , 19 57 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 226 N. Division St. Salisbury, Md. DATE SIGNED 7/17/57							
ACTUAL SIGNATURE Carrie I. Hearn, M.D.				PHYSICIAN'S NAME (Type) CARRIE I. HEARN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Garmel Co., Delmar, Del.				24a. REC'D BY REGISTRAR 22 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 22 1957

RECEIVED

08025

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. LENGTH OF STAY IN 1b 59 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street				d. STREET ADDRESS Main Street			
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Russell				4. DATE OF DEATH Month July Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1897		9. AGE (In years last birthday) yrs 59	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Tender		10b. KIND OF BUSINESS OR INDUSTRY Bridge		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ringold Russell				14. MOTHER'S MAIDEN NAME Margaret Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 239-20-4294		17. INFORMANT Address Mary Russell, Sharptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1957 , to July 4, 1957 (that I last saw the deceased alive on July 4, 1957 , and that death occurred at 9 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharptown, Md. DATE SIGNED 7/5/57							
ACTUAL SIGNATURE H.S. Kuhlman M.D.				PHYSICIAN'S NAME (Type) H.S. Kuhlman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-57		22c. NAME OF CEMETERY OR CREMATORY Riverton,		22d. LOCATION (City, town, or county) (State) Riverton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Gandy, Sharptown, Md.				24. REC'D BY REGISTRAR DATE 8 1957		25. REGISTRAR'S SIGNATURE Mary Owens	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 8 1957

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08001

CERTIFICATE OF DEATH

08010 332
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Wor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GEN HOSPITAL</u>		d. STREET ADDRESS <u>DIV. ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHEL PATTEY SCOTT</u>		4. DATE OF DEATH Month Day Year <u>July 7 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 6, 1883</u>
9. AGE (in years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED P.C. EMPLOYEE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.P. OFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>POWELL PATTEY</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA BOSTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>MRS. MILDRED CARMINE RYDAL PA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/21</u> , 19 <u>57</u> , to <u>7/7/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED ACTUAL SIGNATURE <u>W. S. Ellis Jr.</u> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage Berlin Md</u>		24. REC'D BY REGISTRAR. REGISTRAR'S SIGNATURE <u>Mary H. Harvey</u> DATE <u>JUL 11 1957</u>	

RECEIVED

JUL 11 1957

BUREAU V. S.

08011

337

08002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 7½ months			
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rachel Middle Scott Last Scott				4. DATE OF DEATH Month July Day 23 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/18 98 ?	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 13 Hours 19 Min.		IF UNDER 24 HRS Months 5 Days 13 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO Hospital Records			
17. ADDRESS Hospital Records				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: a. IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerosis, general DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive arteriosclerotic heart disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 3 , 19 56 , to July 23 , 19 57 , that I last saw the deceased alive on July 23 , 19 57 , and that death occurred at 4:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/24/57							
ACTUAL SIGNATURE V. J. Jerman M.D.				PHYSICIAN'S NAME (Type) V. J. Jerman, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial				22b. DATE THEREOF 7/27/57			
22c. NAME OF CEMETERY OR CREMATORY Cornwall Cem				22d. LOCATION (City, town, or county) (State) Queenstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James H. ...				24a. REC'D BY REGISTRAR 6 1957			
24b. REGISTRAR'S SIGNATURE ...				24c. REGISTRAR'S SIGNATURE ...			

MEDICAL CERTIFICATION

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1911

RECEIVED

08012

08003

CERTIFICATE OF DEATH

Reg. Dist. No.

232

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				e. STREET ADDRESS Springhill Road			
3. NAME OF DECEASED (Type or print) First Virginia Middle ELEANOR Last Sinnamon				4. DATE OF DEATH Month July Day 9 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1872	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN SMITH				14. MOTHER'S MAIDEN NAME MINNIE LITTLETON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO NO		17. INFORMANT MR WILLIAM SINNAMON, OCEAN CITY, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis, Pulmonary Emphysema, Pulmonary						INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 28.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-14-55 , 19 55 , to 7-9 , 19 57 , that I last saw the deceased alive on 7-9 , 19 57 , and that death occurred at 1:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Gilmore				DATE SIGNED Salisbury, Md July 9, 1957			
NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/57		22c. NAME OF CEMETERY OR CREMATORY MT. MORIAH		22d. LOCATION (City, town, or county) (State) PHILADELPHIA PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Emma H. Burbage				ADDRESS Berlin Md		24a. REC'D BY REGISTRAR 11 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 11 1957

RECEIVED

08904

CERTIFICATE OF DEATH

Reg. Dist. No.

08013327

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Lincoln Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last SMITH				4. DATE OF DEATH Month July Day 25 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/16/1874	
9. AGE (In years lost birthday) yrs. 83		IF UNDER 1 YEAR: Months 9 Days 9 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Rebecca	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Paul Smith, 507 Lincoln Ave., Salisbury		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 24th, 1957 to July 24th, 1957 , that I last saw the deceased alive on July 24th, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hebron, Maryland DATE SIGNED 7/26/57							
ACTUAL SIGNATURE William Emrich M.D.				DATE SIGNED 7/26/57			
PHYSICIAN'S NAME (Type) William Emrich				ADDRESS Hebron, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/57		22c. NAME OF CEMETERY OR CREMATORY Hebron Cem.		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. L. Messick				ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR IG 6	
24b. REGISTRAR'S SIGNATURE Mary H. Hall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17

JOHN W. D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08026

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08014 327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Willards				c. LENGTH OF STAY IN lb Willards (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.#				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SADIE Middle MAE Last SMITH				4. DATE OF DEATH Month JULY Day 24th Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1911	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 2 Days 21		IF UNDER 24 HRS. Hours 21 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William Marion Reddish				14. MOTHER'S MAIDEN NAME Sarah Ann Causey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Mr. Clarence E. Reddish (Brother)		17. INFORMANT Address Willards Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon-monoxide poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sudden death attributed to carbon monoxide poisoning			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2:20 p.m. 7-27-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Willards		20f. (City or town) (County) (State) Willards Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens		22d. LOCATION (City, town, or county) (State) Near Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 29 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 29 1957

BUREAU V. S.

08015 337

08027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elwood Middle SS. Last Somers			4. DATE OF DEATH Month July Day 19 Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/1872		9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months 5 Days 17 Hours Min. 	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Ship Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Somers				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ----		17. INFORMANT Address Nellie Hopkins, Mount Vernon, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 232 X DUE TO Generalized Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 400.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Aug. 1947 to 19 July 1957 that I last saw the deceased alive on 19 July 1957 , and that death occurred at 2:45 P.M. from the causes and on the date stated above							
ACTUAL SIGNATURE Richard H. Saunders M.D.				DATE SIGNED 7/20/57			
PHYSICIAN'S NAME (Type) Richard H. Saunders				Nanticoke, Maryland 7/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/57		22c. NAME OF CEMETERY OR CREMATORY Turner's Cem.		22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. P. Messitt, Bivalve, Maryland				24a. REC'D BY REGISTRAR 26 1957		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 26 1957

BUREAU V. E.

08016

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Rt. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Bessie		Middle Sharletta		Last Stanley	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH July 11 19 57	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Bridgeville, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Fisher				14. MOTHER'S MAIDEN NAME Alberta Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-5177		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inoperable Ca. of cervix uteri with generalized metastases. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 7/2/ 1957 , to 7/11/ 1957 , that I last saw the deceased alive on 7/11/ 1957 , and that death occurred at 8:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE V. J. German M.D. Deer's Head State Hospital 7/12/57 PHYSICIAN'S NAME (Type) V. J. German, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE 7-15-57		24b. REGISTRAR'S SIGNATURE W. J. N. N. N.	

RECEIVED

JUL 16 1957

BUREAU V. B.

08906

CERTIFICATE OF DEATH

0801737

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Pen. Gen. Hospital d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		2 USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 304 E. Vine St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MARGIE SMITH SULLIVAN		4. DATE OF DEATH Month JULY Day 13 Year 19 57	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 22, 1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Shad Point, Maryland		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Fields		14. MOTHER'S MAIDEN NAME Alverta Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO Mr. George E. Sullivan Jr. (Son)	
17. ADDRESS 304 E. Vine St. Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Complete heart block DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 19 57 , to 7/12 19 57 , that I last saw the deceased alive on 7/12 19 57 , and that death occurred at 7:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 7/15/57 ACTUAL SIGNATURE Dr. Earl Beardsley M.D. PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury, Md. July 15/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR JUL 17 1957 24b. REGISTRAR'S SIGNATURE Mary H. H. Conway	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the above papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08018337
Reg. Dist. No.

08007

1. PLACE OF DEATH a. COUNTY Wicomico Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deers Head State Hospt.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Thomas Middle Beachamp Last Taylor			4. DATE OF DEATH Month July Day 31 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1891	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 8 Days 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer-Plaster (Retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Mordela, Maryland		11. BIRTHPLACE (State or foreign country) U S A	
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13. FATHER'S NAME George W. Steele Taylor		14. MOTHER'S MAIDEN NAME Nettie Wingate	
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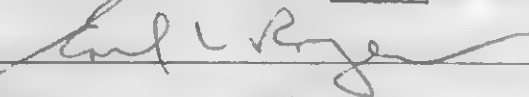
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Virginia D. Lee (Daughter) #10 Benjamin Ave Salisbury, Maryland	
----------------------------------------------------------------------------------	--	-------------------------	--	----------------------------------------------------------------------------------------------	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 102.7 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1434.1 Fractured right hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------------------------------------

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from bed and fractured right hip.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7-20-57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Salisbury (County) Wicomico (State) Id.	

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		7-1-57	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery	
				22d. LOCATION (City, town, or county) (State) Mardela, Maryland	

23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR JUL 5 1957	
				24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registration number, prior to burial, cremation, or removal.

RECEIVED
AUG 5 1957
BUREAU V. A.

08008

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>1 Day</u>				d. STREET ADDRESS <u>406 Park Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MAUD LATTA TODD</u>				4. DATE OF DEATH <u>7 12 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 23, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR <u>12</u> Months <u>19</u> Days <u>57</u> Hours <u>57</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James D. Latta</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Spann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. S. Houston Todd, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>578x</u> DUE TO <u>Ruptured Diverticulum (colon)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, <u>46x</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease; Chronic Bronchitis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. _____ p. m. _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Aug. 28, 1948</u> to <u>July 12, 1957</u> , that I last saw the deceased alive on <u>July 12, 1957</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D. <u>Salisbury, Maryland</u>				DATE SIGNED <u>7/13/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore, Medical Center, Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>7-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08020337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS R.D.# 2 (Spring Hill Rd)			
3. NAME OF DECEASED (Type or print) First DAVID Middle ELTON Last TOWNSEND				4. DATE OF DEATH Month JULY Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 7, 1937		9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 8 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Employee)		10b. KIND OF BUSINESS OR INDUSTRY A. & P. Store		11. BIRTHPLACE (State or foreign country) Salisbury, Md. Pen. Gen. Hosp.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gilbert R. Townsend				14. MOTHER'S MAIDEN NAME Sallie Friscilla Darby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Sallie P. Townsend (Mother) R.D.# 2 Spring Hill Road - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Battered aorta and ruptured diaphragm DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 hours.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Passenger in a car that overburled.					
20c. TIME OF INJURY Month, Day, Year Hour 1:10 a. m. 7-11-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Earl L. Royer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memorial Gardens - Near Hebron, Maryland		22d. LOCATION (City, town, or county) (State) Salisbury Wicomico Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 15 1957		24b. REGISTRAR'S SIGNATURE <i>Mary A. Holloway</i>	

DATE SIGNED
July 12 1957

RECEIVED

JUL 15 1957

BUREAU V. E.

08021

08010 **CERTIFICATE OF DEATH**

Reg. Dist. No. 307

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (if rural give location) 606 Light St.			
3. NAME OF DECEASED (First) ANNIE (Middle) RUTH (Last) TRUITT				4. DATE OF DEATH (Month) JULY (Day) 4 (Year) 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Oct. 6, 1905	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Hiram James Truitt				14. MOTHER'S MAIDEN NAME Martha Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Charles J. Truitt (Brother) Pemberton Salisbury, Maryland			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Portal Embolism						ye	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 7-3-57		19b. MAJOR FINDINGS OF OPERATION Portal Embolism				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. et work		21e. INJURY OCCURRED While et work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-29, 1957, to 7-4, 1957, that I last saw the deceased alive on 7-4, 1957, and that death occurred at 6:35 A.M. from the causes and on the date stated above.							
SIGNATURE Dr. Earl L. Royer				ADDRESS (Street, city, town, state) M.D. Camden Ave. Salisbury, Maryland		DATE SIGNED July 5 / 57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-		DATE THEREOF July 7, 1957		NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		LOCATION (City, town, or county) (State) Pittsville, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			
DATE JUL 10 1957							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. 2

100 8 1957

RECEIVED
JAN 10 1957

C8011

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Troy Middle T. Last Vickers				4. DATE OF DEATH Month July Day 21 Year 1957			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1890		9 AGE (In years last birthday) yrs 67	IF UNDER 1 YEAR Months 6 Days 2	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Allen, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles C. Vickers				14. MOTHER'S MAIDEN NAME Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 		17. INFORMANT Hospital Records		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease, decompensated DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 50x Parkinson Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 18 , 19 57 , to July 21 , 19 57 , that I last saw the deceased alive on July 21 , 19 57 , and that death occurred at 7:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 7/22/57	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/57		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem		22d. LOCATION (City, town, or county) (State) Jesterville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Messer				ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR JUL 26 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 26 1957

BUREAU V. S.

C8012

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 1 Hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 436 Monticello Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM HOWARD WALLER				4. DATE OF DEATH Month 7 Day 26 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1884	
9. AGE (In years last birthday) 73 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Building		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Franklin Waller		14. MOTHER'S MAIDEN NAME Fannie Wingate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-3994		17. INFORMANT Mrs. Florence Ellis Waller, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Arteriosclerosis DUE TO (c) Coronary Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 7 days. 1 year +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 19, 1957 , to July 26, 1957 , that I last saw the deceased alive on July 26, 1957 , and that death occurred at 11:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 224 N. Division St. Salisbury, Md. DATE SIGNED 7/26/57							
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.							
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/57		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland Norman D. Baker				24a. REC'D BY REGISTRAR 7-27-57		24b. REGISTRAR'S SIGNATURE Mary W. Holliday	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 30 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08024

08013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> 75X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>#317 Fairmount Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WATERS</u>		4. DATE OF DEATH Month Day Year <u>July 7th 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7th 1957</u>
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>ERROR</u>	
14. MOTHER'S MARRIED NAME <u>Thelma Elizabeth Waters</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Lewis James Waters - uncle</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PLACENTAL ABRUPTION</u> DUE TO (b) <u>ASPIRATION OF BLOOD</u> DUE TO (c) <u>ANEMIOIC FLUID</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-7</u> , 19 <u>57</u> , to <u>7-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-7</u> , 19 <u>57</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Bone</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>William H. Bone, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Boggs Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Lukes, Som. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis James Waters</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>7-18-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holman</u>

BUREAU V. S.

JUL 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808025
Item 9 FilmG21-5-57 ec
08014
CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>20 yr</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>F. B. Hospital</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>White</u> Last <u>White</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-10</u> AGE (In years, months, days) <u>47</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>VR</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>25-07-9234</u>		17. INFORMANT <u>Jarvis White</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema.</u> DUE TO (b) <u>Left ventricular failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hypertensive C.V. disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Dr. Johnson has attended since past 5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/25/1957</u> to <u>7/25/1957</u> , that I last saw the deceased alive on <u>7/25/1957</u> , and that death occurred at <u>12:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>211 Maryland Ave. Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>O. J. BURTON</u>				DATE SIGNED <u>7/29/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Borker Wilcock</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Aug 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Marjorie H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUG 1 1957

U.S. AIR FORCE

08028

CERTIFICATE OF DEATH

 08026 332
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bridge St		d. STREET ADDRESS Bridge St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First MARION Middle WILLIAM Last WILKINSON		4. DATE OF DEATH Month JULY Day 25 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 11 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - Seaford Garment Co. (Shirt Factory)		10b. KIND OF BUSINESS OR INDUSTRY Mardela, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Wilkinson		14. MOTHER'S MAIDEN NAME Lillie Seabrease	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO Mrs. Laura T. Wilkinson (Wife)	
17. INFORMANT Mardela, Maryland		Address Bridge St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myelogenous leukemia			
DUE TO 111			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 57 , to last , 19 57 , that I last saw the deceased alive on 7/24 , 19 57 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 100 Crown Delmar, Del		DATE SIGNED 7/26/57	
ACTUAL SIGNATURE Ernest M. Larmore M.D.			
PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore		Delmar, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		22d. LOCATION (City, town or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTERED FUNERAL REGISTRAR'S SIGNATURE Ray H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 30 1957

BUREAU V. S.

08029

CERTIFICATE OF DEATH

Reg. Dist. No.

338

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Parsonsborg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village				d. STREET ADDRESS In Village			
3. NAME OF DECEASED (Type or print) First Middle Last LEONARD COOPER WILLIAMSON				4. DATE OF DEATH Month Day Year JULY 14 th 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1901	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 10	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bridgeville, Delaware	
13. FATHER'S NAME John Mitchell Williamson				14. MOTHER'S MAIDEN NAME Anne Elizabeth Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Elizabeth P. Williamson (Wife) Parsonsborg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to 7/14 , 19 57 , that I last saw the deceased alive on 7/15/57 and that death occurred at 10:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St. Salisbury, Maryland DATE SIGNED July 16/57							
ACTUAL SIGNATURE Fred R. Gramse M.D.		PHYSICIAN'S NAME (Type) Dr. Fred Gramse					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg, Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 18 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

RECEIVED

JUL 18 1957

BUREAU V. 2

C8015

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 32 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 New York Ave.,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury d. STREET ADDRESS 208 New York Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA First Middle Last WIMBROW		4. DATE OF DEATH Month Day Year 7 28 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sec.		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Wimbrow		14. MOTHER'S MAIDEN NAME Eliza Isabell Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-05-0564	
17. INFORMANT Mrs. John Melson, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1			
INTERVAL BETWEEN ONSET AND DEATH Dr. GRANSE has been attending for 15 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/28/1957 to 7/28/1957 , that I last saw the deceased alive on 7/28/1957 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 7/1/1957			
ACTUAL SIGNATURE [Signature] M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) Dr. O.J. Burton 211 Maryland Ave., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/57	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland Norman D. Baker		24a. REC'D BY REGISTRAR DATE 7-30-57	
24b. REGISTRAR'S SIGNATURE Maryell Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
AUG 1 1957
BUREAU V. 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08030

CERTIFICATE OF DEATH

08029

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardella				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Mardella			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rt #2 Delmar, Del.			
3. NAME OF DECEASED (Type or print) Nancy First Braxton Middle Winder Last				4. DATE OF DEATH 7 Month 25 Day 19 Year 57			
5. SEX F. M.		6. COLOR OR RACE AA		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1908	
9. AGE (In years lost birthday) 49 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Essex Co., Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Matthew Braxton				14. MOTHER'S MAIDEN NAME Selina Gaines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Isaac Winder, Rt#2 Delmar, Del. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with cerebral embolism 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X							INTERVAL BETWEEN ONSET AND DEATH 1 month
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 57 , to 7/25/57 , that I last saw the deceased alive on 7/23 , 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward M. Lawrence M.D.				ADDRESS (Street, city or town, state) Delmar, Del.		DATE SIGNED 7/25/57	
PHYSICIAN'S NAME (Type) E. M. Lawrence							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Nebo Cemetery		22d. LOCATION (City, town, or county) (State) Columbia, Del	
23. FUNERAL DIRECTOR'S SIGNATURE J. P. Stewart Funeral Home, Salisbury, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary H. Hallaway	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John William		Male		45		March 1, 1905		St. Louis, Mo.	
Cause of Death		Disease		Manner		Time		Place	
Heart Failure		Myocardial Infarction		Natural		10:15 AM		Home	
Physician		Hospital		Burial		Interment		Cemetery	
Dr. J. H. Smith		St. Louis Hospital		St. Louis Cemetery		Section 1		Lot 123	
Signature of Registrar		Signature of Physician		Signature of Burial Officer		Signature of Interment Officer		Signature of Cemetery Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JUL 31 1957

RECEIVED